

**FLORIDA DEPARTMENT
OF
INSURANCE**

**MARKET CONDUCT
REPORT OF EXAMINATION**

OF

PROTECTIVE LIFE INSURANCE COMPANY

AS OF

December 31, 1998

DIVISION OF INSURER SERVICES

**BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT**

MARKET CONDUCT SECTION

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October 8, 1999

Honorable Bill Nelson
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, Florida 32399-0300

Dear Commissioner Nelson:

Pursuant to the provisions of Section 627.3161, Florida Statutes, and in accordance with your Letter of Authority and the resolutions adopted by the National Association of Insurance Commissioners (NAIC), a Market Conduct Examination has been performed on:

Protective Life Insurance Company
2801 Highway 280 South
Birmingham, Alabama 35223

at its Main Administrative Office in Birmingham, Alabama. The report of such examination is herein respectfully submitted.

INTRODUCTION

Protective Life Insurance Company, hereinafter is generally referred to as "the Company" when not otherwise qualified.

This is the first Market Conduct Examination conducted by the Florida Department of Insurance, hereinafter generally referred to as "the Department".

This Market Conduct Examination commenced on May 6, 1999, and concluded on October 8, 1999.

SCOPE OF EXAMINATION

This examination covers the period of the Company's operation in the State of Florida from January 1, 1996, through December 31, 1998; and where considered appropriate, transactions and affairs subsequent to the examination period.

The purpose of this Market Conduct Examination was to determine if the Company's practices and procedures conform with the Florida Statutes and the Florida Administrative Code.

Statistical information is included in this examination report. The National Association of Insurance Commissioners' Examination Handbook standards of 7% error ratio for claim resolution procedures and 10% error ratio for other procedures are applied.

Any error appearing to be a pattern or a general business practice has been included in this examination report.

The examination included, but was not limited to, the following areas of the Company's operation:

1. Sales Brochures and Advertisements
2. Appointment and Termination of Agents
3. Policy Forms, Rates and Underwriting
4. Claims and Complaint Handling Procedures

Files were examined on the basis of file content at the time of examination. Comments and recommendations were made in those areas in need of correction or improvement.

DESCRIPTION OF COMPANY

History

Protective Life Insurance Company is domiciled in the State of Tennessee and is a stock life insurance company that is a wholly-owned subsidiary of Protective Life Corporation. The Company was licensed to transact insurance business in the State of Florida on June 20, 1921.

Certificate of Authority

The Company was authorized to write the following lines of business in the State of Florida, subject to compliance with all applicable laws and regulations of Florida:

Code 400-Life

Code 405-Variable Annuities

Code 410-Group Life and Annuities

Code 420-Variable Life

Code 440-Credit Life and Health

Code 441-Credit Disability

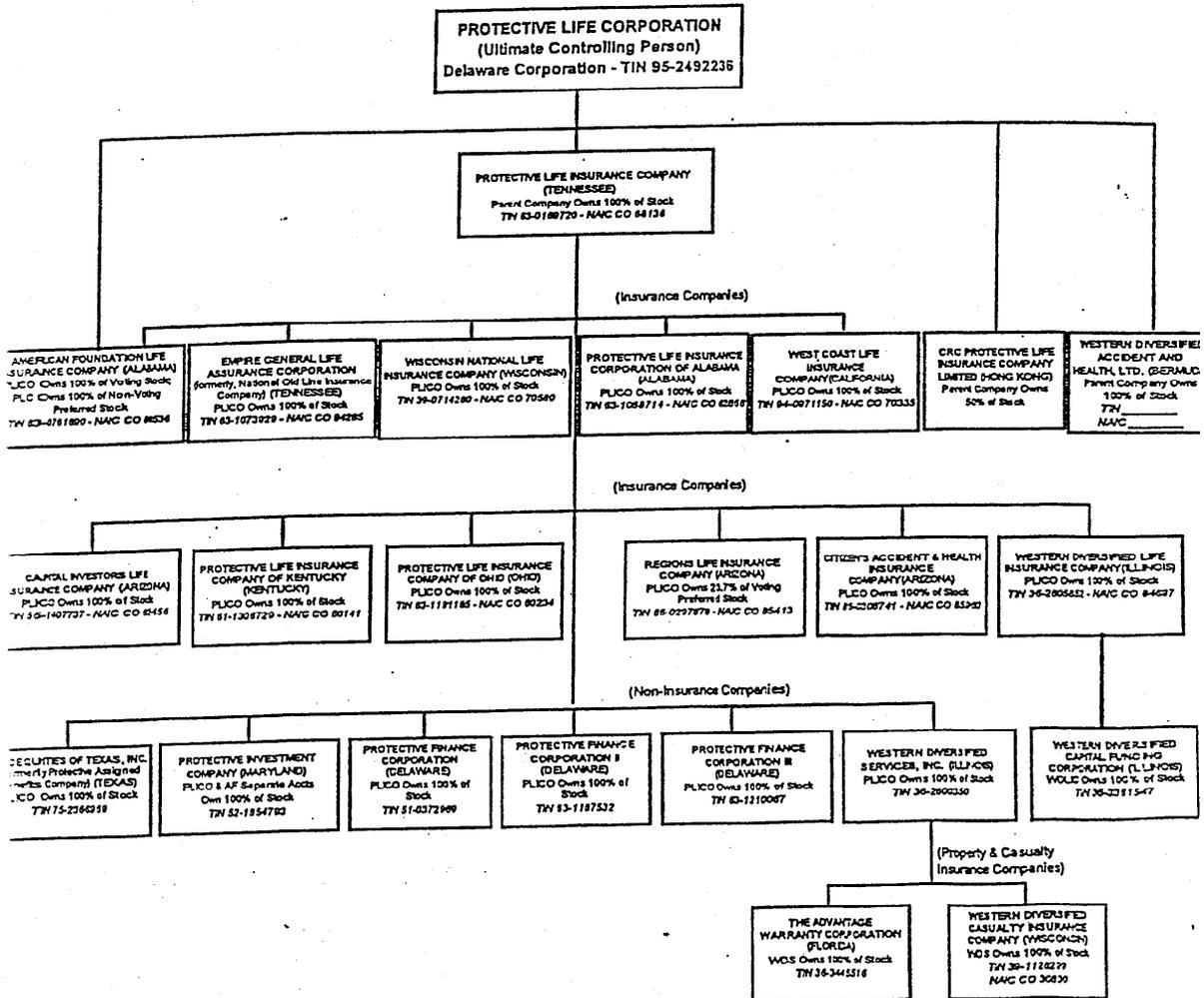
Code 450-Accident and Health

Organizational Chart(s)

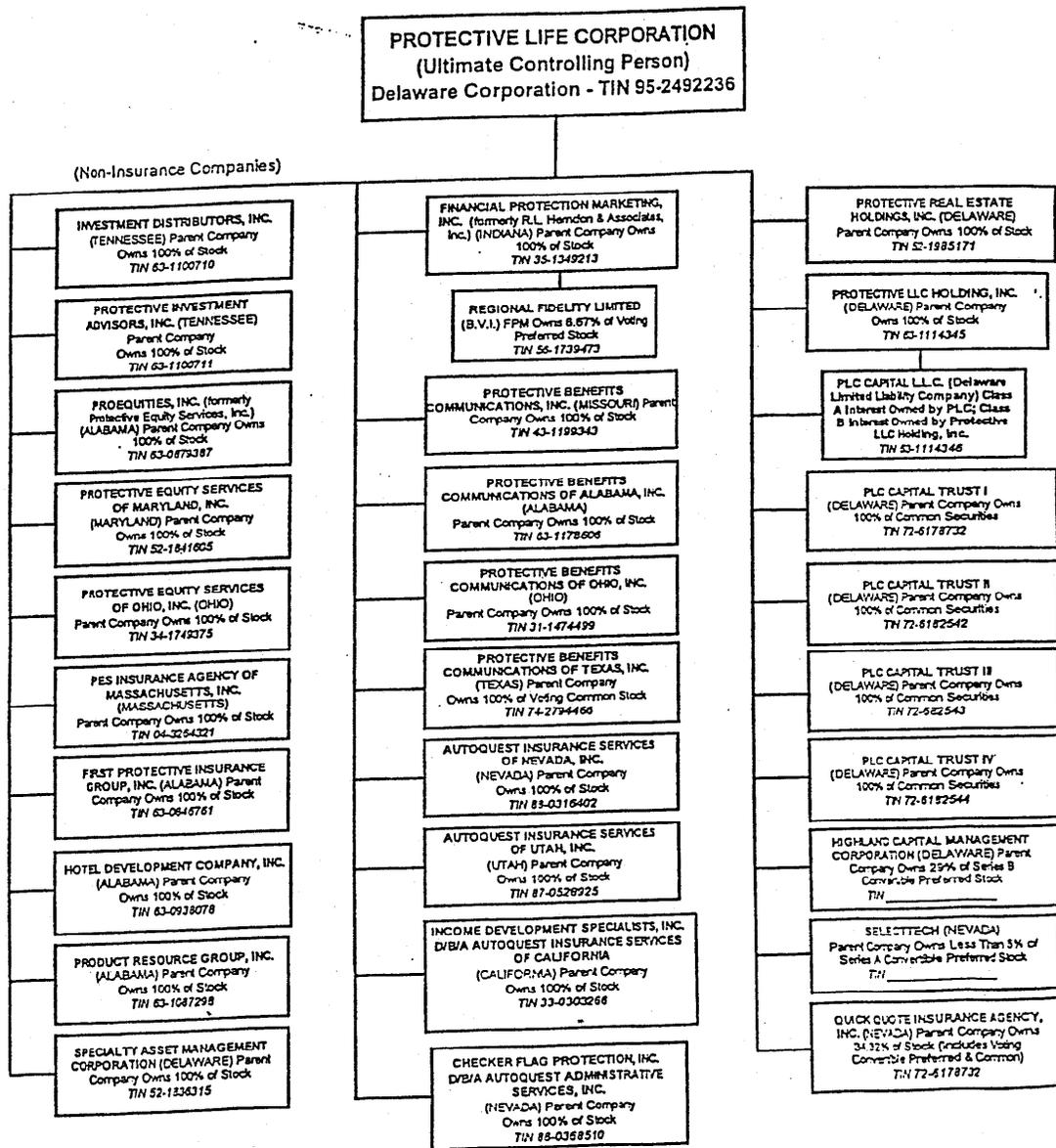
The Company's organizational charts are shown on the following pages.

**PROTECTIVE LIFE CORPORATION
ORGANIZATIONAL CHART
AS OF JANUARY 28, 1999**

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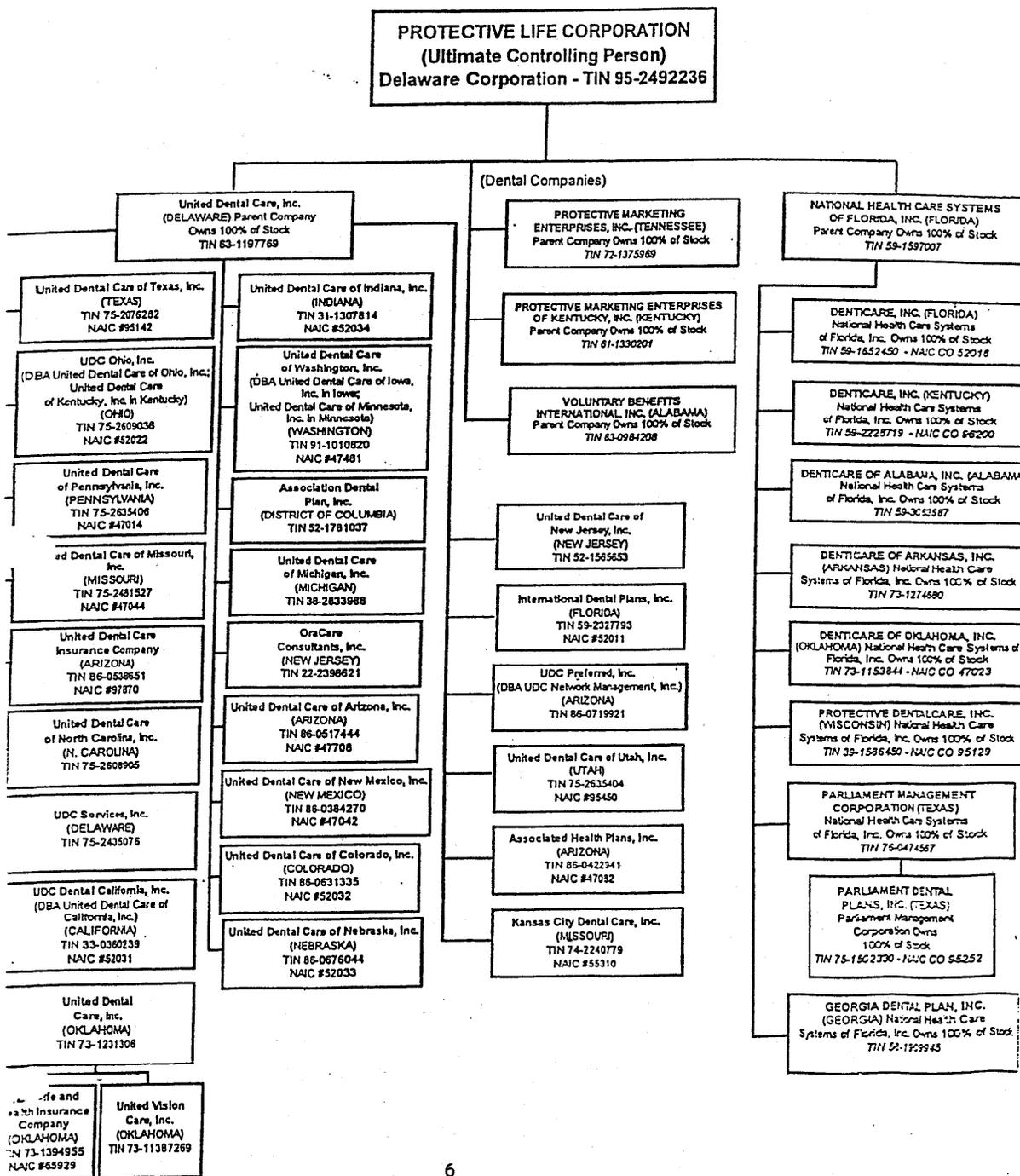


PROTECTIVE LIFE CORPORATION
 ORGANIZATIONAL CHART
 AS OF JANUARY 28, 1999



**PROTECTIVE LIFE CORPORATION
ORGANIZATIONAL CHART
AS OF JANUARY 28, 1999**

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TERRITORY AND PLAN OF OPERATION

Protective Life Insurance Company is authorized to transact insurance business in forty-nine (49) states, District of Columbia, Puerto Rico, Guam, and the Commonwealth of Northern Mariana Islands.

The Company markets and services their products through the use of various distribution channels using Independent Agents, Broker/Dealers, direct response methods, agents affiliated with Financial Institutions and Financial Planners.

During the period under review, the lines written were:

1. Life
2. Accident and Health
3. Group Life
4. Credit Life and Health
5. Credit Disability
6. Variable Annuity
7. Variable Life

The Company withdrew from writing small employer group health insurance in July 1997.

During the period under review, the Company did not write any lines of insurance business for which they were not authorized on their Certificate of Authority, as required by Section 624.401 (2), Florida Statutes.

The Company has developed and implemented a business plan to address potential computer system problems associated with the Year 2000. The Company's Year 2000 Preparedness Plan incorporates safeguards for business partners for whom the Company and its insureds rely. The Company has responded to Year 2000 regulatory inquiries and surveys from the Securities & Exchange Commission, the Arizona Insurance Department, and the Tennessee Insurance Department.

SALES AND ADVERTISEMENTS

Marketing materials provided to the examiner representing all advertisements utilized by the Company were examined to determine conformity with Rule 4-150, Florida Administrative Code. No discrepancies were noted.

The Company maintains an advertising file in accordance with Rules 4-150.018(1), 4-150.119(1), and 4-150.217(1)(a), Florida Administrative Code.

The Company filed Certificates of Compliance for Advertising with its Annual Statement for 1996, 1997 and 1998 as required by Rules 4-150.018(2), 4-150.119(2), and 4-150.217(2), Florida Administrative Code.

AGENT APPOINTMENT, RENEWAL AND TERMINATION

The Company's agent appointment and license renewal practices were reviewed. No discrepancies were noted.

Twenty-five (25) terminated agent files were examined to determine proper reporting to the Department by the Company as prescribed by Section 626.511(2), Florida Statutes. No discrepancies were noted.

Additional appointments were made as required by Section 626.341, Florida Statutes, when business was accepted from a licensed agent who was not previously appointed by the Company.

POLICY FORM AND RATE FILINGS

The Company maintains a file containing copies of policies, rates, riders, endorsements and correspondence appropriate thereto of all forms filed and approved by the Department.

Company filings for 1996, 1997 and 1998, were reviewed to determine if policy forms being used by the Company had been stamped "filed" or "approved" by the Department as required by Sections 627.410, 627.6785 and 627.682, Florida Statutes and Rule 4-163, Florida Administrative Code.

No discrepancies were noted.

UNDERWRITING AND RATE SURVEY

The underwriting and rate survey included an analysis of the following Company procedures:

1. Basic underwriting guidelines
2. Proper issuance of forms, riders and endorsements
3. Proper use of rates
4. Correspondence during the policy issue process

APPLICATION REVIEW

Applications for life, health, and credit life and health insurance were surveyed.

A random sample of four hundred twenty-eight (428) files, from a total population of three thousand one hundred eighty-five (3,185) for 1996, 1997 and 1998, was reviewed.

The files reviewed revealed the agents were appointed as required by Sections 626.112 and 627.683, Florida Statutes. Applications and related forms used were those filed and approved by the Department as required by Section 627.682, Florida Statutes.

INSURED'S RIGHT TO RETURN POLICY

A sample of forty-one (41) files, from a total population of forty-one (41), for 1996, 1997 and 1998, was reviewed.

The review indicated that the Company complied with Rule 4-154.003, Florida Administrative Code, and Sections 626.99(4)(a) and 627.674 (4)(d), Florida Statutes and refunds were handled in a timely manner.

REPLACEMENT OF INSURANCE

The Company maintains a replacement register as required by Rule 4-151.007(3)(e) and 4-151.008 and (2)(a) Florida Administrative Code.

Copies of "Notice to Applicant" regarding replacement of life or health insurance, comparative information form and proposed insurance and all sales proposals were maintained as required by Rules 4-151.007(3)(e), 4-151.008(2)(a) and (b), and 4-151.105(1), Florida Administrative Code.

Copies of "Notice to Applicant" were not being sent within the specified time to existing insurers whose policies were being

replaced as required by Rules 4-151.007(3) and 4-151.105(3), Florida Administrative Code.

Fifty (50) files, from a total population of one thousand eight hundred ninety-seven (1,897) for Individual Life Insurance and one hundred (100) files from a total population of four hundred ninety-nine (499) for Individual Accident and Health Insurance for the years 1996, 1997 and 1998, were reviewed and the following discrepancies were noted.

For the required "Notice to the Existing Insurer" for life insurance replacement, one (1) notice was not mailed, and five (5) replacement notice records were not mailed within five (5) working days as prescribed by 4-151.007(3), Florida Administrative Code.

For Accident and Health insurance, during the year 1996, ten (10) "Notice to the Existing Insurer" replacement notices were not issued and/or mailed, and one (1) notice was not mailed within five (5) working days as prescribed by 4-151.105(3), Florida Administrative Code. For the year of 1997, five (5) replacement notices were not issued. For the year of 1998, no exceptions were noted.

Also, it was noted during this review, that applications were not consistently date stamped upon receipt. Micro-fiche records of "Notice to Applicant" and "Notice to Existing Insurer" copies were not always maintained in an easily retrievable and legible manner.

There were no replacements of Medicare Supplement Insurance for the years under examination, 1996, 1997 and 1998.

NONFORFEITURE OPTIONS AND AUTOMATIC PREMIUM LOANS

A random sample of eighty-four (84) nonforfeiture option files, from a total population of eighty (80) Extended Term, twenty-four (24) Paid-Up Insurance and sixty-five (65) Automatic Premium Loans was reviewed. All cases indicated the values and terms were correctly calculated and were processed in a timely manner.

Policy Loan Benefits were reviewed to determine if the interest charged was appropriate and within the statutory limits established by Sections 627.458 and 627.4585, Florida Statutes.

A random sample of thirty (30) files were reviewed from a total population of one hundred one (101). No discrepancies were noted.

Cash surrenders of life or annuity policies were reviewed to determine if interest was paid after thirty (30) days in compliance with Section 627.482, Florida Statutes.

A random sample of thirty (30) files was reviewed from a total population of one thousand two hundred sixty (1,260). No discrepancies were noted.

In the event of non-payment of premium where there is not Automatic Premium Loan election on the application, the Company automatically initiates premium loan from the insured's cash value. The Automatic Premium Loan takes place on the sixty-fifth (65th) day following the premium due date.

These procedures comply with the requirements of Section 627.476, Florida Statutes, Standard Non-Forfeiture Law for Life Insurance.

CANCELLATIONS AND NONRENEWALS

A random sample of one hundred three (103) credit life and credit disability files, from a population of two thousand seven hundred ninety-eight (2,798) were reviewed. All files were canceled and refunded as required by the various parts of Rule 4-163.003, Florida Administrative Code.

As a result of the Company's approval by the Department to withdraw from the small employer group health market, its plans were non-renewed effective February 28, 1998.

CLAIMS ADMINISTRATION

The Company has established claim settlement procedures intended to maintain control of all claims from the time of receipt to the time of final payment. Claims are handled in various divisional

offices around the country and reported to the Home Office of the Company.

The Claims Managers have certified that they have read and understand Section 626.9541(1)(i), Florida Statutes, relating to unfair claim settlement practices.

TIME STUDY FOR PAID AND DENIED CLAIMS

Claims were randomly selected and reviewed for compliance with:

1. Contract provisions
2. Timeliness and accuracy of payments
3. Supporting documentation
4. Unfair claim settlement practices

A time study for paid and denied claims was conducted to determine the "calendar days" required to process a claim after receiving proper proof of loss.

The term "calendar days" included Saturday, Sunday and holidays. Cycle time used in the analysis was for the following groups of days: 1-45, 46-120, 121 and over.

The population of processed paid and denied claims for the examination period reviewed is as follows:

Individual Life Claims - Paid

1996	282 Claims for	\$ 6,344,179
1997	281 Claims for	\$ 9,426,333
1998	<u>331</u> Claims for	<u>\$ 8,700,907</u>
Total	894 Claims for	\$24,471,419

Individual Life Claims - Denied

1996	0 Claims
1997	2 Claims
1998	<u>1</u> Claim
Total	3 Claims

Group Life Claims - Paid

1996	5 Claims for	\$ 73,700
1997	5 Claims for	\$ 51,000
1998	<u>4</u> Claims for	<u>\$ 90,000</u>
Total	14 Claims for	\$214,700

Group Life Claims - Denied

There were no Group Life claims denied for the years under examination.

Individual Health Claims - Paid

1996	4,225 Claims for	\$12,143,651
1997	4,787 Claims for	\$15,194,811
1998	<u>4,400</u> Claims for	<u>\$15,569,768</u>
Total	13,412 Claims for	\$42,908,230

Individual Health Claims - Denied

1996	1,046 Claims
1997	1,155 Claims
1998	<u>1,033</u> Claims
Total	3,234 Claims

Group Health Claims - Paid

1996	16,795 Claims for	\$1,881,039
1997	21,365 Claims for	\$2,109,475
1998	<u>30,979</u> Claims for	<u>\$3,116,232</u>
Total	69,139 Claims for	\$7,106,746

Group Health Claims - Denied

1996	3,668 Claims
1997	4,562 Claims
1998	<u>6,488</u> Claims
Total	14,718 Claims

Medicare Supplement Claims-Paid

1996	1,980 Claims for	\$ 516,108
1997	1,675 Claims for	\$ 467,682
1998	<u>1,595</u> Claims for	<u>\$ 531,033</u>
Total	5,250 Claims for	\$1,514,823

Medicare Supplement Claims-Denied

1996	594 Claims
1997	522 Claims
1998	<u>450</u> Claims
Total	1,566 Claims

Credit Life Claims-Paid

1996	21 Claims for	\$143,336
1997	33 Claims for	\$284,839
1998	<u>24</u> Claims for	<u>\$190,637</u>
Total	81 Claims for	\$618,812

Credit Life Claims-Denied

1996	4 Claims
1997	9 Claims
1998	<u>10</u> Claims
Total	23 Claims

Six Hundred Seventy One (671) claim files from the above-listed population were reviewed. The results of the review are as follows:

CALENDAR DAYS/PERCENTAGE OF CLAIMS

Individual Life Claims - Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>100</u>	<u>100%</u>
Total	100	100%

The average time required to process a claim was seven (7) days.

Individual Life Claims-Denied

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>3</u>	<u>100%</u>
Total	3	100%

The average time required to process a denied claim was one (1) day.

Individual Health Claims-Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>100</u>	<u>100%</u>
Total	100	100%

The average time required to process a claim was seven (7) days.

Individual Health Claims-Denied

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>100</u>	<u>100%</u>
Total	100	100%

The average time required to process a denied claim was seven (7) days.

Group Life Claims-Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>14</u>	<u>100%</u>
Total	14	100%

The average time required to process a claim was one (1) day.

Group Health Claims-Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	45	90%
Unable to determine	<u>5</u>	<u>10%</u>
Total	50	100%

The average time required to process a claim was eight (8) days.

Group Health Claims-Denied

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	49	98%
46-120	<u>1</u>	<u>2%</u>
Total	50	100%

The average time required to process a denied claim was seven (7) days.

Medicare Supplement Claims-Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>50</u>	<u>100%</u>
Total	50	100%

The average time required to process a claim was five (5) days.

Medicare Supplement Claims-Denied

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>50</u>	<u>100%</u>
Total	50	100%

The average time required to process a denied claim was five (5) days.

Credit Life Claims-Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>80</u>	<u>100%</u>
Total	80	100%

The average time required to process a claim was five (5) days.

Credit Life Claims-Denied

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>6</u>	<u>100%</u>
Total	6	100%

The average time required to process a denied claim was three (3) days.

Credit Health Claims-Paid

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>48</u>	<u>100%</u>
Total	48	100%

The average time required to process a claim was five (5) days.

Credit Health Claims-Denied

<u>Calendar Days</u>	<u>Number of Claims</u>	<u>Percentage</u>
1-45	<u>20</u>	<u>100%</u>
Total	20	100%

The average time required to process a denied claim was ten (10) days.

An analysis of the claim study revealed the following:

1. A random sample of four hundred forty-two (442) paid claim files from a total population of eighty-eight thousand nine hundred forty-five (88,945) was reviewed to determine if benefits were being allowed according to the policy contract as required by Section 626.877, Florida Statutes. No discrepancies were noted.
2. A random sample of six hundred seventy-one (671) documented claim files from a total population of eighty-eight thousand nine hundred forty-five (88,945) was reviewed to determine if claims had been processed in a timely manner as required by Sections 627.613 and 627.657(2), Florida Statutes. No discrepancies were noted.

3. A random sample of one hundred (100) life claims from a total population of eight hundred ninety-four (894) was reviewed to determine if the 11% interest, or interest at an annual rate equal to or greater than the Moody's Corporate Bond Yield Average-Monthly Average Corporate as to the day the claims were received and not less than 8% on claims after January 1, 1993 was paid in accordance with Section 627.4615, Florida Statutes. No discrepancies were noted.
4. A random sample of one hundred (100) individual health claim files from a total population of thirteen thousand four hundred twelve (13,412) was reviewed to determine if the 10% interest due on certain claims was paid as required by Section 627.613(6), Florida Statutes. No discrepancies were noted.
5. A random sample of six hundred seventy-one (671) claim files from a total population of eighty-eight thousand nine hundred forty-five (88,945) was reviewed to determine if the required Fraud Statement was included on the claim forms as required by Section 817.234(1)(b), Florida Statutes.

With respect to the Life Claim Form used during the period under review, the "Fraud Statement" wording was printed in substance to comply with 817.234, Florida Statutes, however, the form failed to reference "third degree felony."

The Company's Credit Life and Credit Disability Claim Forms No. P-5118-Ed-4/93 and P-5126-Ed-5/93, which were utilized during the

period under review, did not contain a "Fraud Statement", in violation of Section 817.234(1)(b), Florida Statutes.

During the time study review of individual health claims, it was noted that thirteen (13) of the initial claim files selected failed to indicate the date of receipt. It was further noted that thirty-one (31) of the initial claim files selected failed to include a copy of the actual claim forms. It was determined that the company does not always require the submission of a claim form to process benefits. The lack of date stamps for making a compliance determination as to the timely payment of claims was brought to the company's attention. Additional file selections were made in order to complete the time study on documented files.

The company's failure to maintain adequate records is a violation of Section 624.318(2), Florida Statutes.

INSURER EXPERIENCE REPORTING

The Company did not file Consumer Guide Information Forms DI4-331 and DI4-333 as to policies of individual health insurance and is not in compliance with Section 627.9175, Florida Statutes.

The Company filed Experience Reports, Forms DI4-272, DI4-273, DI4-274, DI4-275 and DI4-276, as required by Rule 4-163.012, Florida Administrative Code, regarding Credit Life and Disability Insurance.

COMPLAINTS

The Company maintains complaint-handling procedures as required by Section 626.9541(1)(j), Florida Statutes.

The Company maintained a complete record of all complaints received during the period under review as required by Section 626.9541(1)(j), Florida Statutes.

Seventy (70) complaints (17%), from a total population of four hundred twenty (420), for 1996, 1997 and 1998 were reviewed to determine the number of calendar days taken to resolve a complaint from the time of receipt to the final disposition. Calendar days included workdays, weekends and holidays.

The results of the review are as follows:

<u>Calendar Days</u>	<u>Number of Complaints</u>	<u>Percentage</u>
1-15	76	76%
16-30	16	16%
31 and over	<u>8</u>	<u>8%</u>
Total	100	100%

The average number of days to handle a complaint for the entire review period was fifteen (15).

As a result of an increased volume in consumer complaints filed with the Department of Insurance, the examination was expanded to

include a review of all complaints for the period January 1, 1999 through June 30, 1999.

It was brought to the Company's attention that the number of complaints requiring more than thirty-one (31) days to resolve was of concern. It was further recommended that the company review its complaint handling procedures to improve efficiency in this policyholder service area.

Due to the increased complaint concerns, with emphasis on claims handling, the Company contacted and visited its third party administrator, American Chambers Life Insurance Company, during the examination period. It was reported to the examiner that a claim backlog had developed as a result of American Chambers' conversion to a new computer system resulting in delays in the repricing of PPO claims. A weekly reporting process has been initiated between the Company and its administrator to monitor improvements in the area of claims handling and overall customer service.

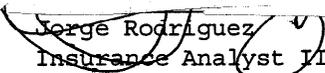
1999 COMPLAINT REVIEW

<u>Calendar Days</u>	<u>Number of Complaints</u>	<u>Percentage</u>
1-15	39	78%
16-30	8	16%
31-45	<u>3</u>	<u>6%</u>
Total	50	100%

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners have been followed in performing the Market Conduct Examination of Protective Life Insurance Company as of December 31, 1998, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,


Jorge Rodriguez
Insurance Analyst II
Florida Insurance Department